# Chapter 1. Introduction and Methods

In 1999, Congress directed the Agency for Healthcare Research and Quality (AHRQ) to produce an annual report, starting in 2003, to track "prevailing disparities in health care delivery as it relates to racial factors and socioeconomic factors in priority populations."[1]  Although the emphasis is on disparities related to race, ethnicity, and socioeconomic status (SES), this directive includes a charge to examine disparities in "priority populations"—groups with unique health care needs or issues that require special focus.

The first National Healthcare Disparities Report (NHDR) was a comprehensive national overview of disparities in health care among racial, ethnic, and socioeconomic groups in the general U.S. population and among priority populations.  It was released in 2003 with its companion report, the National Healthcare Quality Report (NHQR); the reports emphasize the interdependence of efforts to measure and address quality and disparities in health care and are intended to be used as companion documents.

This second NHDR is built upon the 2003 report and continues to include a comprehensive national overview of disparities in America.  In addition, in the 2004 report, a second critical goal of the report series is developed—tracking the Nation's progress towards the elimination of health care disparities.  Additional years of data are added that begin to allow examination of changes in disparities over time.

Together, the 2004 NHDR and NHQR are designed to provide policymakers with a snapshot of the current status of disparities and quality in American health care and an assessment of how disparities and quality are changing over time.  In addition, tools used to create these reports are available in the appendixes.  Health care providers and payers may apply these tools to their own data to assess their performance relative to the national benchmarks included in the reports.

## Health Care Disparities

In the 2003 NHDR, the lack of consensus on a definition of "disparities" was noted.  For example, in *Healthy People 2010* (HP2010), in pursuit of the overarching goal of eliminating health disparities, all differences among populations in measures of health and health care are considered evidence of disparities.[2]  At the other end of the spectrum, in the report by the Institute of Medicine (IOM), *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, disparities are defined as differences that remain after taking into account patient needs and preferences and the availability of health care.[3]  Still others associate health care disparities with adverse health outcomes, personal responsibility, or provider prejudice.

To monitor and track progress in eliminating disparities over time, national data on disparities are needed.  Because existing Federal data typically do not capture patient needs or preferences for care, in the NHDR a broad definition of disparities is used and, consistent with HP2010, any differences among populations are considered disparities.  While many differences in care are documented in this report, no inferences about *causes* of disparities should be drawn.  Specifically, findings about racial and ethnic differences in care should not be interpreted as evidence of racial or ethnic bias in the health care system.

## New Developments in Addressing Health Care Disparities

In the 2003 report, a small sample of the many programs in the Department of Health and Human Services (HHS) and in the private sector that focus on reducing disparities in health and health care were listed.  This past year, substantial contributions to the understanding of disparities have been made, while other activities have led the Nation closer to the goal of eliminating disparities in health care, including:

- **Department of Health and Human Services Disparities Council**—This group convenes leaders from across HHS under the Assistant Secretary for Health to coordinate and maximize the effectiveness of the many Federal initiatives in place to eliminate disparities and to identify and evaluate new opportunities for eliminating disparities.  It relies upon the NHDR and other efforts to measure and track disparities to help focus Federal action and monitor progress.

- **National Business Group on Health Employer Toolkit for Reducing Racial and Ethnic Health Disparities**—Developed in partnership with many of America's leading companies, including Pfizer, Verizon, Texas Instruments, Coca-Cola, and Kellogg, this resource includes summaries of disparities research for corporate audiences, the business case for reducing disparities, and best practices for helping employees overcome barriers to care.

- **National Health Plan Learning Collaborative To Reduce Disparities and Improve Quality**—Ten of America's foremost health plans, including Aetna, Anthem, Cigna, Harvard Pilgrim, HealthPartners, Highmark, Kaiser Permanente, Molina, UnitedHealth Group, and WellPoint, have joined with the Agency for Healthcare Research and Quality and the Robert Wood Johnson Foundation to improve race and ethnicity data collection and develop interventions to reduce disparities in treatment of diabetes and other chronic conditions.  Lessons learned by plans in the collaborative will be shared with the health care community.

- **American Public Health Association National Public Health Week**—The 2004 theme, Eliminating Health Disparities, brought the public health community together to advance understanding of disparities and develop resources for improvement, including a Health Disparities Community Solutions Database with 500 initiatives launched by communities.

- **National Research Council report on collection of data for addressing disparities**—The report, *Eliminating Health Disparities: Measurement and Data Needs*, found that current data on race, ethnicity, and socioeconomic position are severely limited and made recommendations to HHS and States for improving data collection.

- **America's Health Insurance Plans/Robert Wood Johnson Foundation Collection of Racial and Ethnic Data by Health Plans Survey**—This study found that more than half of the Nation's health insurance plans collect information on the race, ethnicity, and primary language of their membership to identify enrollees with risk factors, reduce disparities, assess variation, and identify need for interpreters and translated materials.

- **Health Research and Educational Trust/Commonwealth Fund report on collection of racial and ethnic data by hospitals**—This report, *Who, When, and How: The Current State of Race, Ethnicity, and Primary Language Data Collection in Hospitals*, found that more than three-fourths of the Nation's hospitals collect patient race and ethnicity information and that most hospitals do not see any drawbacks to collecting such information.

- **Institute of Medicine and Agency for Healthcare Research and Quality reports on health literacy**— In *Health Literacy: A Prescription to End Confusion*, the IOM found that almost half of Americans have difficulty understanding and acting upon health information and that these people with limited health literacy use hospitals and emergency rooms more often and generate higher health care costs. In *Literacy and Health Outcomes*, AHRQ found that low reading skill and poor health are related across a variety of medical conditions.

- **Trans-HHS Cancer Health Disparities Progress Review Group** — This group brought together researchers, health practitioners, advocates, and cancer survivors to make recommendations to HHS about how to eliminate the unequal burden of suffering and death due to cancer. The Progress Review Group report, *Making Cancer Health Disparities History*, is a detailed and integrated 3-year plan.

## How This Report Is Organized

In addition to the Highlights summarizing key themes from the 2004 report, the basic structure of the report is unchanged from last year and consists of the following:

- **Chapter 1: Introduction and Methods** documents the organization, data sources, and methods used in the 2004 report and describes major changes from the 2003 report.

- **Chapter 2: Quality of Health Care** examines disparities in quality of health care in the general U.S. population. Measures of quality of health care used in this chapter are identical to measures used in this year's NHQR except when data to examine disparities are unavailable. Sections cover four components of health care quality: effectiveness, patient safety, timeliness, and patient centeredness; the effectiveness section is subdivided by medical condition.

- **Chapter 3: Access to Health Care** examines disparities in access to health care in the general U.S. population. Sections cover four components of health care access: getting into the health care system, getting care within the health care system, patient perceptions of care, and health care utilization.

- **Chapter 4: Priority Populations** examines disparities in quality of and access to health care among AHRQ's priority populations including:

    - Racial and ethnic minorities
    - Low income groups
    - Women
    - Children
    - Elderly
    - Residents of rural areas
    - Individuals with special health care needs

Appendixes are available online (www.qualitytools.ahrq.gov) and include:

- **Appendix A: Data Sources** provides information about each database analyzed for the NHDR including data type, sample design, and primary content.
- **Appendix B: Detailed Methods** provides detailed methods for select databases analyzed for the NHDR.
- **Appendix C: Measure Specifications** provides information about how to generate each measure analyzed for the NHDR. It includes both measures highlighted in the report text as well as other measures that were examined but not included in the text. It also includes information about the summary measures used in the report.
- **Appendix D: Data Tables** provides detailed tables for most measures analyzed for the NHDR, including both measures highlighted in the report text and measures examined but not included in the text. A few measures cannot support detailed tables and are not included in the appendix. When data are available, race tables and ethnicity tables are stratified by age, gender, residence location, and one or more socioeconomic variables (household income, education, insurance, and/or area income). When data are available, socioeconomic tables are stratified by age, gender, residence location, race, and ethnicity. Summary data tables organized by topic are presented first followed by detailed data tables for each measure.

## New in This Report

Consistent with the goal of improving quality of and access to health care for all Americans, a number of improvements in the quality and accessibility of the NHDR are made this year. Improvements include changes to report format, changes to the measure set, addition of new data sources, expanded analyses, and summary of disparities.

## Changes to Report Format

The expansion of the 2004 report with the inclusion of new measures, data, and analyses prompted a reassessment of the report format. With broad support across HHS, the 2004 NHDR and NHQR have been restructured as chartbooks. This format allows more detailed discussion of a subset of the NHDR measures. These highlighted measures are the focus of report text. All measures are still presented in the summary tables at the end of Chapters 2 and 3 as well as in the appendixes.

The Interagency Work Group for the NHDR helped identify disparities to highlight. These highlighted measures were published in the *Federal Register* for public review and comment. In addition to the criteria for inclusion in the original measure set (importance, scientific soundness, feasibility), new criteria were established for selecting highlighted measures, including:

- **Recency of data**—Measures with newer data were favored.
- **Proximity to care**—Process measures were favored over outcome measures.
- **Clinical significance**—Measures with greater clinical significance were favored.
- **Methodological soundness**—Measures with fewer methodological caveats were favored.
- **Prevalence**—Measures affecting more people were favored over measures affecting fewer people.

- **Generalizability**—Measures that apply to the general population were favored over measures unique to specific populations.
- **Specificity**—Measures that are specific for a particular condition were favored over measures that are not specific.
- **Number of comparisons**—Measures that support more comparisons by race, ethnicity, and SES were favored over measures that support fewer comparisons.

Each section in the 2004 report begins with a description of the importance of the section's topic. Then, figures and bullets highlight findings related to a small number of measures relevant to this topic. When data are available, these figures typically show contrasts by:

- **Race**—Blacks, Asians, Native Hawaiians and Other Pacific Islanders (NHOPIs), American Indians and Alaska Natives (AI/ANs), and people of more than one race compared with whites.
- **Ethnicity**—Hispanics compared with non-Hispanic whites.
- **Income**—Poor, near poor, and middle income people compared with high income people.[i]
- **Education**—People with less than a high school education and high school graduates compared with people with any college education.

When information for more than a single data year is available, figures illustrate trends over time. When data support stratified analyses, a figure showing racial and ethnic differences stratified by SES is included. As in last year's report, bullets focus on findings that meet report criteria for importance;[ii] comparisons not discussed in bullets do not meet these criteria. However, absence of differences that meet criteria for importance should not be interpreted as absence of disparities. Often, large differences between groups did not meet our criteria for statistical significance because of small sample sizes and limited power. In addition, significance testing used in this report does not take into account multiple comparisons.

## Changes to the Measure Set

The measure set used in this report has been improved in several ways. First, measures that reflect problems for only a very small number of Americans, that were extremely limited by small sample sizes, or that relied on databases which are not repeated regularly and hence cannot be used to analyze trends were dropped. Second, a handful of measures were modified to reflect more current standards of care. Third, age adjustment[iii] for a number of measures was updated. Finally, a number of new measures were added to fill identified gaps, including measures of:

- Inpatient mortality for select acute conditions and procedures from the Healthcare Cost and Utilization Project (HCUP).

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[i] Throughout this report, "poor" is defined as having family incomes less than 100% of the Federal poverty level; "near poor," between 100% and 199%; "middle income," between 200% and 399%; and "high income," 400% or more of the Federal poverty level.

[ii] Criteria for importance are that the difference is statistically significant at the alpha=0.05 level, two-tailed test and that the relative difference is at least 10% different from the reference group when framed positively as a favorable outcome or negatively as an adverse outcome. For trends, the least recent year is used as the reference group and the most recent year is tested against that year.

[iii] Age-adjusted measures are labeled as such. All other measures are not age adjusted.

- Nursing home quality from the Minimum Data Set (MDS) developed by the Centers for Medicare & Medicaid Services (CMS) between last year's and this year's NHDR.
- Children's preventive services and counseling collected in the Medical Expenditure Panel Survey (MEPS) beginning in 2001.
- Quality of care for the elderly from the Medicare Current Beneficiary Survey (MCBS).

Measure revisions were proposed and reviewed in meetings of the Interagency Work Group for the NHDR, which includes representation from across HHS, and then published in the *Federal Register* for public comment.

## Addition of New Data Sources

Although the 2003 report included over two dozen databases (Table 1.1), gaps were noted. This year, new sources of data were identified and added to help fill these gaps. As in the 2003 report, standardized suppression criteria were applied to all databases to support reliable estimates.[iv] New data added this year come from:

- Medicare Patient Safety Monitoring System, which includes information from chart reviews about patient safety events among hospitalized Medicare beneficiaries.
- Indian Health Service (IHS) facilities, which include information about hospital care received by American Indians and Alaska Natives in IHS service areas.
- Health Resources and Services Administration (HRSA) Community Health Center User Survey, which includes information about care delivered in community health centers (CHCs).
- National Survey of Children with Special Health Care Needs, which includes information about disabled and chronically ill children.

## Expanded Analyses

In the 2004 report, the accumulation of more than a single year of data for many measures allows reporting of change over time. While changes over 2 years of data are difficult to interpret, it is hoped that future reports with additional years of data will be able to document progress towards the elimination of health care disparities. For some measures, longer trends are presented because public use files typically include multiple years of data. For example, recent releases from the Surveillance, Epidemiology, and End Results program include cancer registry data from 1992 to 2001. For data sources that typically produce single year public use files, only years of data gathered for the 2003 and 2004 reports are shown. Older data, while often available from data sources, are not used.

**Multivariate analyses.** The presentation of disparities is also expanded to include more multivariate models and analyses stratified by SES. Because racial and ethnic minorities are disproportionately of lower SES populations, health care disparities among racial and ethnic minorities are often highly correlated with

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iv Estimates based on sample size fewer than 30 or with relative standard error greater than 30% were considered unreliable and suppressed. Databases with more conservative suppression criteria were allowed to retain them.

disparities that fall along socioeconomic lines. To begin to distinguish between disparities related to race and ethnicity and disparities related to SES, multivariate analyses are needed.

Multivariate analyses are presented for several measures to begin to disentangle the independent effects of different SES measures on racial and ethnic disparities. For consistency across models, a general logistic r egression model was developed that adjusts for age, gender, household income, education, insurance, and residence location. This model was applied to measures to quantify racial effects relative to whites and ethnic effects relative to non-Hispanic whites after controlling for these covariates; results are shown as odds ratios. Only the National Health Interview Survey and MEPS include data to support these models. Results for several MEPS measures are presented in the 2004 report; results for other measures will be added in future iterations of this report. Multivariate results are presented in the report for:

- Diabetes services
- Patient perceptions of need
- Difficulty getting care
- Patient-provider communication
- Patient-provider relationship

**Stratified analyses.** Stratified analyses also help to disentangle the effects of race and ethnicity from the effects of SES on health care. In addition, racial and ethnic effects often differ across socioeconomic groups and socioeconomic effects often differ across racial and ethnic groups; stratified analyses illustrate these interaction effects clearly. All measures presented in this report are tabulated to allow stratified analyses whenever possible. These tables (see Appendix D) allow examination of racial and ethnic differences within specific income and education groups and examination of SES differences within specific racial and ethnic groups. Stratified analyses are presented in the report for:

- Influenza vaccination (Figure 2.6)
- Health insurance (Figure 3.2)
- Problems getting referral to a specialist (Figure 3.6)
- Office or outpatient visits (Figure 3.10)
- Prenatal care (Figure 4.16)
- Childhood vaccination (Figure 4.19)
- Pneumonia vaccination among the elderly (Figure 4.27)
- Family-centered care among children with special health care needs (Figure 4.38)
- Health insurance among children with special health care needs (Figure 4.40)

## Summary of Disparities

In the 2004 report, efforts to summarize disparities have been refined. In the Highlights and in Chapter 4, Priority Populations, a subset of measures for which comparable data are available for 2000 and 2001 are highlighted. This subset consists of 38 measures of effectiveness of health care and 31 measures of access to health care. Because mortality and health care utilization are strongly affected by factors other than health care, such as genetic predisposition, lifestyle, comorbid conditions, and environmental and social determinants, these measures are not included in the summary measures. Data sources are:

- Surveillance, Epidemiology, and End Results (SEER) program
- U.S. Renal Data System (USRDS)
- Medical Expenditure Panel Survey (MEPS)
- Centers for Disease Control and Prevention (CDC) AIDS Surveillance System
- National Vital Statistics System-Natality (NVSS-N)
- National Immunization Survey (NIS)
- National Health Interview Survey (NHIS)
- National Hospital Discharge Survey (NHDS)

For each measure, racial, ethnic, and socioeconomic groups are compared with an appropriate comparison group; each group could receive care that is worse than, about the same as, or better than the comparison group. For each group, the percentages of measures for which the group received worse care, similar care, or better care were calculated. Note that data from the AIDS Surveillance System and NIS used in the summary measures are for 2000 and 2001, while data from these databases presented elsewhere in this report are for 2002.

Data on all measures were not available for all groups. Hence, summary measures should only be used to quantify differences between a specific group and its comparison group. Comparisons of different racial and ethnic minority groups (i.e., blacks vs. AI/ANs) would not be appropriate. See Tables 1.2 and 1.3 for lists of measures available for each group and Appendix C for data on each measure for each group.

**Table 1.1. Databases used in the 2004 NHDR (new databases in bolded italics)**

**Surveys collected from samples of civilian, noninstitutionalized populations:**

- AHRQ, Medical Expenditure Panel Survey (MEPS), 1999-2001
- CDC-NCHS, National Health Interview Survey (NHIS), 1999-2001
- CDC-NCHS/National Immunization Program, National Immunization Survey (NIS), 2000-2002
- *CDC-NCHS, National Survey of Children with Special Health Care Needs (NSCSHCN), 2002*
- CMS, Medicare Current Beneficiary Survey (MCBS), 1998-2000
- *HRSA, Community Health Center User Survey, 2002*
- SAMHSA, National Survey on Drug Use and Health (NSDUH), 2001-2002

**Data collected from samples of health care facilities and providers:**

- CDC-NCHS, National Ambulatory Medical Care Survey (NAMCS), 1999-2001
- CDC-NCHS, National Hospital Ambulatory Medical Care Survey-Outpatient Department (NHAMCS-OPD), 1999-2001
- CDC-NCHS, National Hospital Ambulatory Medical Care Survey-Emergency Department (NHAMCS-ED), 1999-2001
- CDC-NCHS, National Hospital Discharge Survey (NHDS), 1998-2001
- CMS, End Stage Renal Disease Clinical Performance Measures Project (ESRD CPMP), 2001-2002

**Data extracted from data systems of health care organizations:**

- AHRQ, Healthcare Cost and Utilization Project State Inpatient Databases disparities analysis file[i] (HCUP SID), 2001
- *CMS, Medicare Patient Safety Monitoring System, 2002*
- CMS, Nursing Home Minimum Data Set, 2002
- CMS, Quality Indicators program, 2000-2001
- HIV Research Network data (HIVRN), 2001
- *IHS, National Patient Information Reporting System (NPIRS), 2002*
- NIH, United States Renal Data System (USRDS), 1998-2001

**Data from surveillance and vital statistics systems:**

- CDC-National Center for HIV, STD, and TB Prevention, HIV/AIDS Surveillance System, 2001
- CDC-National Center for HIV, STD, and TB Prevention, TB Surveillance System, 2000
- CDC-NCHS, National Vital Statistics System (NVSS), 2000-2001
- NIH, Surveillance, Epidemiology, and End Results (SEER) program, 1992-2001

[i] This file is designed to provide national estimates of disparities in the AHRQ Quality Indicators using weighted records from a sample of hospitals from the following 22 States: AZ, CA, CO, CT, FL, GA, HI, KS, MD, MA, MI, MO, NJ, NY, PA, RI, SC, TN, TX, VA, VT, and WI. For details, see Appendix, A, Data Sources, and Appendix C, Measure Specifications.

**Table 1.2. Availability of measures of effectiveness of health care with comparable data for 2000 and 2001 for different racial, ethnic, and socioeconomic groups**

| Measure | Data source | Black | Hispanic | Asian or API | AI/AN | Poor |
|---|---|:---:|:---:|:---:|:---:|:---:|
| Rate of late stage breast cancer (Stage II and higher) among women age 40 and over | SEER | ✔ | ✔ | ✔ | ✔ | |
| Rate of invasive cervical cancer among women age 20 and over | SEER | ✔ | ✔ | ✔ | ✔ | |
| Rate of late stage colorectal cancer (regional and distant) among people age 50 and over | SEER | ✔ | ✔ | ✔ | ✔ | |
| Dialysis patients registered on the waiting list for transplantation | USRDS | ✔ | ✔ | ✔ | ✔ | |
| Persons receiving a kidney transplant within 3 years of date of renal failure | USRDS | ✔ | ✔ | ✔ | ✔ | |
| Adults with diabetes who had a hemoglobin A1c measurement at least once in past year | MEPS | ✔ | ✔ | | | ✔ |
| Adults with diabetes who had a lipid profile in past 2 years | MEPS | ✔ | ✔ | | | ✔ |
| Adults with diabetes who had a retinal eye examination in past year | MEPS | ✔ | ✔ | | | ✔ |
| Adults with diabetes who had a foot examination in past year | MEPS | ✔ | ✔ | | | ✔ |
| Adults with diabetes who had an influenza immunization in past year | MEPS | ✔ | ✔ | | | ✔ |
| Smokers receiving advice to quit smoking | MEPS | ✔ | ✔ | | | ✔ |
| New AIDS cases among persons ages 13 and over | CDC AIDS Surveillance | ✔ | ✔ | ✔ | ✔ | |
| Pregnant women receiving prenatal care in first trimester | NVSS-N | ✔ | ✔ | ✔ | ✔ | |
| Live-born infants with low birthweight (<2,500 grams) | NVSS-N | ✔ | ✔ | ✔ | ✔ | |
| Live-born infants with very low birthweight (<1,500 grams) | NVSS-N | ✔ | ✔ | ✔ | ✔ | |
| Infant mortality per 1,000 live births, all | NVSS-N | ✔ | ✔ | ✔ | ✔ | |
| Infant mortality per 1,000 live births, birthweight >2,499 grams | NVSS-N | ✔ | ✔ | ✔ | ✔ | |
| Infant mortality per 1,000 live births, birthweight 1,500-2,499 grams | NVSS-N | ✔ | ✔ | ✔ | ✔ | |
| Infant mortality per 1,000 live births, birthweight <1,500 grams | NVSS-N | ✔ | ✔ | ✔ | ✔ | |
| Maternal deaths per 100,000 live births | NVSS-N | ✔ | ✔ | | | |

✔Indicates that reliable data on measure are available for this group and included in summary across measures of quality for this group.

Key: API=Asian or Pacific Islander; AI/AN=American Indian or Alaska Native; Poor=Individuals with household incomes <100% of Federal poverty thresholds.

**Table 1.2. Availability of measures of effectiveness of health care with comparable data for 2000 and 2001 for different racial, ethnic, and socioeconomic groups (continued)**

| Measure | Data source | Black | Hispanic | Asian or API | AI/AN | Poor |
|---|---|---|---|---|---|---|
| Children 19-35 months who received all recommended vaccinations | NIS | ✔ | ✔ | ✔ | ✔ | ✔ |
| Children 19-35 months who received 4 doses of diphtheria-tetanus-pertussis (DTaP) vaccine | NIS | ✔ | ✔ | ✔ | ✔ | ✔ |
| Children 19-35 months who received 3 doses of polio vaccine | NIS | ✔ | ✔ | ✔ | ✔ | ✔ |
| Children 19-35 months who received 1 dose of measles-mumps-rubella vaccine | NIS | ✔ | ✔ | ✔ | ✔ | ✔ |
| Children 19-35 months who received 3 doses of H. influenzae type b (Hib) vaccine | NIS | ✔ | ✔ | ✔ | ✔ | ✔ |
| Children 19-35 months who received 3 doses of hepatitis B vaccine | NIS | ✔ | ✔ | ✔ | ✔ | ✔ |
| Children 19-35 months who received 1 dose of varicella vaccine | NIS | ✔ | ✔ | ✔ | ✔ | ✔ |
| Adolescents (13-15) who received 3 or more doses of hepatitis B vaccine | NHIS | ✔ | ✔ | | | ✔ |
| Adolescents (13-15) who received 2 or more doses of measles-mumps-rubella vaccine | NHIS | ✔ | ✔ | | | ✔ |
| Adolescents (13-15) who received 1 or more doses of diphtheria-tetanus booster | NHIS | ✔ | ✔ | | | ✔ |
| Adolescents (13-15) who received 1 or more doses of varicella vaccine | NHIS | ✔ | ✔ | | | ✔ |
| Children 2-17 with a dental visit | MEPS | ✔ | ✔ | ✔ | | ✔ |
| High risk persons 18-64 who received influenza vaccine in past year | NHIS | ✔ | ✔ | ✔ | ✔ | ✔ |
| People 65 and over who received influenza vaccine in the past year | NHIS | ✔ | ✔ | ✔ | | ✔ |
| High risk persons 18-64 who ever received pneumococcal vaccination | NHIS | ✔ | ✔ | | | ✔ |
| People 65 and over who ever received pneumococcal vaccination | NHIS | ✔ | ✔ | ✔ | | ✔ |
| Hospital admissions for asthma per 100,000 population under 18 | NHDS | ✔ | | | | |
| Hospital admissions for asthma per 100,000 population 18 and over | NHDS | ✔ | | | | |

✔ Indicates that reliable data on measure are available for this group and included in summary across measures of quality for this group.

Key: API=Asian or Pacific Islander; AI/AN=American Indian or Alaska Native; Poor=Individuals with household incomes <100% of Federal poverty thresholds.

**Table 1.3. Availability of measures of access to health care with comparable data for 2000 and 2001 for different racial, ethnic, and socioeconomic groups**

| Measure | Data source | Black | Hispanic | Asian or API | AI/AN | Poor |
|---|---|---|---|---|---|---|
| People under 65 with health insurance | NHIS | ✔ | ✔ | ✔ | ✔ | ✔ |
| People under 65 with public health insurance only | NHIS | ✔ | ✔ | ✔ | ✔ | ✔ |
| People under 65 with any private health insurance | NHIS | ✔ | ✔ | ✔ | ✔ | ✔ |
| People 65 and over with any private health insurance | NHIS | ✔ | ✔ | ✔ | | ✔ |
| People uninsured all year | MEPS | ✔ | ✔ | ✔ | ✔ | ✔ |
| People with any period of uninsurance during the year | MEPS | ✔ | ✔ | ✔ | ✔ | ✔ |
| People with any period of public insurance during the year | MEPS | ✔ | ✔ | ✔ | ✔ | ✔ |
| People who have a specific source of ongoing care | NHIS | ✔ | ✔ | ✔ | ✔ | ✔ |
| People in fair or poor health with a specific source of ongoing care | NHIS | ✔ | ✔ | ✔ | | ✔ |
| People with a hospital, emergency room, or clinic as source of ongoing care | NHIS | ✔ | ✔ | ✔ | ✔ | ✔ |
| People without a usual source of care who indicate a financial or insurance reason for not having a source of care | MEPS | ✔ | ✔ | | | ✔ |
| People who have a usual primary care provider | MEPS | ✔ | ✔ | ✔ | ✔ | ✔ |
| Families that experience difficulties or delays in obtaining health care or do not receive needed care | MEPS | ✔ | ✔ | ✔ | | ✔ |
| Families that experience difficulties or delays in obtaining health care due to financial or insurance reasons | MEPS | ✔ | ✔ | | | ✔ |
| Families that did not receive a doctor's care or prescription medications because the family needed the money | MEPS | ✔ | ✔ | | | ✔ |
| Families not very satisfied that they can get health care if they need it | MEPS | ✔ | ✔ | ✔ | | ✔ |

✔ Indicates that reliable data on measure are available for this group and included in summary across measures of access for this group.

Key: API=Asian or Pacific Islander; AI/AN=American Indian or Alaska Native; Poor=Individuals with household incomes <100% of Federal poverty thresholds.

**Table 1.3. Availability of measures of access to health care with comparable data for 2000 and 2001 for different racial, ethnic, and socioeconomic groups (continued)**

| Measure | Data source | Black | Hispanic | Asian or API | AI/AN | Poor |
|---|---|---|---|---|---|---|
| People who sometimes or never get appointments for routine care as soon as wanted | MEPS | ✔ | ✔ | ✔ | | ✔ |
| People who sometimes or never get care for illness or injury as soon as wanted | MEPS | ✔ | ✔ | | | ✔ |
| People with provider who has office hours nights or weekends | MEPS | ✔ | ✔ | ✔ | ✔ | ✔ |
| People with difficulty getting appointments on short notice | MEPS | ✔ | ✔ | ✔ | ✔ | ✔ |
| People with difficulty contacting provider over the telephone | MEPS | ✔ | ✔ | ✔ | ✔ | ✔ |
| Adults without problems getting referral to a specialist in past year | MEPS | ✔ | ✔ | | | ✔ |
| People not very satisfied with professional staff at provider's office | MEPS | ✔ | ✔ | ✔ | ✔ | ✔ |
| People who usually wait over 30 minutes before seeing provider | MEPS | ✔ | ✔ | ✔ | ✔ | ✔ |
| People with provider who usually asks about medications and treatments other doctors may give | MEPS | ✔ | ✔ | ✔ | ✔ | ✔ |
| Adults whose providers sometimes or never listened carefully to them | MEPS | ✔ | ✔ | ✔ | | ✔ |
| Adults whose providers sometimes or never explained things in a way they could understand | MEPS | ✔ | ✔ | ✔ | | ✔ |
| Adults whose providers sometimes or never showed respect for what they had to say | MEPS | ✔ | ✔ | ✔ | | ✔ |
| People not satisfied with quality of care received from provider | MEPS | ✔ | ✔ | ✔ | ✔ | ✔ |
| Adults whose providers sometimes or never spent enough time with them | MEPS | ✔ | ✔ | ✔ | | ✔ |
| Adults who rate their health care in the past year <7 on a scale from 0 to 10 | MEPS | ✔ | ✔ | ✔ | | ✔ |

✔Indicates that reliable data on measure are available for this group and included in summary across measures of access for this group.

Key: API=Asian or Pacific Islander; AI/AN=American Indian or Alaska Native; Poor=Individuals with household incomes <100% of Federal poverty thresholds.

# References

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